STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155656	A. BUILDING _____ B. WING _____	C 10/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY NURSING AND REHABILITATION CENTER	**2827 NORTHGATE BLVD FORT WAYNE, IN 46835**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00155955 and IN00157086.

Complaint IN00155955 - Substantiated, no deficiencies related to the allegations were cited.
Complaint IN00157086 - Substantiated, no deficiencies related to the allegations were cited.

Survey Dates: September 30 & October 1, 2014

Facility number: 000275
Provider number: 155656
AIM number: 100290930

Survey team:
Angela Strass, RN

Census bed type:
SNF/NF: 113
Total: 113

Census payor type:
Medicare: 9
Medicaid: 87
Other: 17
Total: 113

Sample: 4

Canterbury Nursing and Rehabilitation Center was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00155955 and Complaint IN00157086.

Quality Review 10/02/14 by Lisa McColly

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE